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The Rhode Island Catastrophic Health Insurance Program: The First Three Years

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Abstract

This is a descriptive analysis of the first three years of operation of a state-sponsored Catastrophic Health Insurance Program (CHIP), initiated by the state of Rhode Island in 1975. Expenses covered by this program are related to family income and existing private insurance coverage. Data derived from the administration of the program and description of recipients of CHIP benefits and data relating to the characteristics of the state's entire population form the basis for this study. The data show that all age-sex groups were represented, but that people over 44 years of age were overrepresented among the CHIP recipients. The data also demonstrated that no income group and no insurance coverage group is immune from catastrophic out-of-pocket expenditures. However, the low-income groups and the uninsured were more likely to qualify for CHIP relative to their proportion in the population. Medical conditions accounting for catastrophic expenditures include dread diseases such as cancer and heart disease. However, other conditions not commonly thought to be catastrophic, such as mental illness, normal delivery, and appendectomy were also included. The inflationary potential of CHIP was explored and it was determined that less than one-half of one percent of total expenditure for the entire state was paid under this program. Further research would permit more accurate consideration of costs of possible national catastrophic programs.

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February 1981

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Foreword

The Rhode Island Catastrophic Health Insurance Program (CHIP) is a state-funded program, begun in 1975, to protect residents of the state from "catastrophic" out-of-pocket medical expenses. This study is a descriptive analysis of the first three years of operation of this program—the first of its kind in the area of state-funded catastrophic health insurance. Expenses covered by this program are related to family income and existing private insurance coverage. Data derived from the administration of the program and description of recipients of CHIP benefits and data relating to the characteristics of the state's entire population form the basis for this study.

The experience of CHIP for the first three years shows that although low-income groups and the uninsured are more likely to qualify for CHIP relative to their proportion in the population, no group is completely exempt from catastrophic out-of-pocket health care expenditures. Although chronic and fatal conditions are predominant, the proportion of recipients who seem to have recovered is adequate enough to suggest that the economic benefits of the program seem to outweigh the costs. The per capita costs of CHIP have been modest in the first three years; and the inflationary potential of the program seems smaller than other major health care financing programs.

There are limitations of the CHIP program as examined in the context of a comprehensive national health care plan. It does not assure comprehensive health care coverage nor increase the availability of ambulatory and preventive services; nor does it contribute to aggressive cost containment, stimulate greater efficiency in the health care system, nor control unnecessary health care spending. It is not the answer to all the problems confronting the American health care scene. However, this first look at the operational experience under a catastrophic out-of-pocket health care cost program suggests that more years of data on the Rhode Island program would provide better knowledge of the outcomes of program recipients and facilitate analysis of the pro-

gram's effectiveness. It would also allow an evaluation of the long-term effects of the program on the basic pattern of health insurance coverage and the observation and analysis of annual program growth after the start-up period has passed. It is expected that data from Rhode Island could be combined with data from states with similar programs to allow better estimates of expected program costs for other geographic regions; and in the near future, consideration can be given to the costs of possible national catastrophic programs.

Gerald Rosenthal, Ph.D.
February 1981

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Background

The debate over the proper role of the Federal government in the provision of health care to its people has been discussed for years. In the absence of a consensus concerning national health insurance, some states have begun to enact their own health insurance programs. Two approaches are being used: Connecticut and Hawaii mandate the availability of comprehensive private insurance; Rhode Island, Maine, Minnesota, and, recently, New York, have enacted catastrophic health insurance plans.

Rhode Island's program is called the Catastrophic Health Insurance Plan (CHIP) and mandates basic health plan benefits much the same as the Hawaii program does; however, Hawaii's program is considered in the "comprehensive" column. Emphasis is the key in distinguishing catastrophic from comprehensive: whether the sponsors are out to solve the problem of catastrophic expense as in Rhode Island, or whether they are out to upgrade the benefits in health insurance generally, as in Hawaii. Many other states have considered or are considering one or both of these approaches.

This study examines the experience of the Rhode Island program during the first three years.

Description of the program

In April 1974, Rhode Island became one of the first states to enact a catastrophic health insurance program.[1] The Rhode Island Catastrophic Health Insurance Plan (CHIP) is a state-funded program designed to protect residents of the state from "catastrophic" out-of-pocket expenses due to the treatment of adverse medical conditions. The CHIP program became effective January 1, 1975, and is oriented toward an economic definition of the term "catastrophic," summing all the allowable expenditures (as defined by the regulations) for a family unit in a yearly period. Any individual deemed eligible for coverage of health services determined to be catastrophic remains eligible for coverage during the calendar year in which he becomes so entitled and during the following calendar year—if such expenses are incurred for health costs which are at least equal to 25 percent of the amount of what the personal resource payment (out-of-pocket expense or deductible) would have been during the former year of catastrophic coverage. This amount shall then be eligible for catastrophic coverage during the following year.

Eligibility for financial payment under CHIP depends on the following criteria:

(a) Residency: An eligible person must have been a resident of Rhode Island for at least three months and must not have moved to Rhode Island for the primary purpose of receiving benefits from the CHIP program.

(b) Health Care Costs: An eligible person must have incurred a financial obligation for allowable medical expenses in excess of a financial criterion which is dependent on both family income and family health insurance coverage.

(c) Alternative Payers: All other sources of private, state or federal health insurance coverage for which the family is eligible must have been exhausted.

Limitations of coverage are defined in the law. They include:

Health care services not covered by CHIP:

(a) Benefits provided pursuant to the laws of the United States including, but not limited to military service-connected disabilities, medical services provided for employees of the Armed Forces of the United States, medical services financed for the benefit of persons over the age of 65 years of age and for persons with insufficient income and assets to purchase benefits pursuant to the laws of the United States, and medical services which may be financed in the future on behalf of all citizens by the United States.

(b) Care which is primarily for custodial or domiciliary purpose and is not medically necessary.

(c) Cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure.

(d) Dentistry and optometry unless prescribed as medically necessary as the result of an injury or serious illness or disability.

(e) Chiropractic and psychological therapy and social counseling unless prescribed as medically necessary.

(f) Corrective appliances and artificial aids, such as hearing aids, corrective lenses and eyeglasses, unless such appliances and aids are medically necessary for the purpose of rehabilitation.

(g) Drugs and medication legally requiring prescriptions unless such items are medically necessary.

(h) Drugs and medication not legally requiring prescriptions.

(i) Outpatient psychiatric care in excess of fifty percent (50 percent) of the cost incurred in a calendar year.

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[1] The State of Maine enacted a similar program in March 1974. Its program became effective July 1, 1974.

(j) Services delivered in facilities which have not been certified by the director of the department of health as qualified to provide such services.

Such health care services not allowed under CHIP indicate widespread coverage and show much similarity to the exclusion found in the most comprehensive private packages available.

The personal resource payment

After payment by other health insurance resources (private health insurance includes Blue Cross/Blue Shield, commercial insurance and health maintenance organizations), the amount of money which a family must pay out-of-pocket (personal resource payment -PRP- or deductible) before being eligible for CHIP payments is related to a person's health insurance coverage and, except for Medicare beneficiaries, to family income.

Several levels of health insurance coverage are recognized under the CHIP plan. The "fully qualified" coverage is defined as full coverage of 120 days of inpatient hospital care, covered physician and surgical care that is associated with the inpatient care, and at least $10,000 major medical coverage. The second level, "semi-qualified" insurance, covers hospitalization and physician services as defined above, but lacks major medical insurance. "Non-qualified" insurance describes any other insurance coverage. Those eligible for Medicare by virtue of age or long-term disability are treated separately.

The deductible a family must pay out-of-pocket (for "allowable" medical expense) is summarized in Table 1. Family income is measured by adjusted gross income as computed for IRS tax forms. The PRP for families with fully-qualified insurance is the greater of $500 or 10 percent of the family income spent on eligible medical services in a calendar year. A family covered by semi-qualified insurance must spend $1,250 or 25 percent of income on medical services to qualify. For non-qualified insurance, the

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Table 1. Insurance coverage and personal resource payment

Type of insurance coverage	*Characteristics*	*Personal resource payments*
Qualified insurance	Semi-private hospital coverage at least 120 days Medical-surgical coverage for usual and customary charges Major medical coverage with no more than 20 percent coinsurance and at least $10,000 in supplemental coverage	The greater of $500 or 10 percent of allowable income*
Semi-qualified insurance	As above except no major medical insurance	The greater of $1,250 or 25 percent of allowable income
Non-qualified insurance	Insurance not described above	The difference between what is paid by the insurance and what would be paid by qualified insurance up to a maximum of $1,500 plus the personal resource payment for qualified insurance
Medicare only		$1,000
Medicare supplemented by private health insurance		$ 500
No health insurance		The greater of $5,000 or 50 percent of allowable income

* Allowable income is adjusted gross income less dependents' allowances as defined by the Internal Revenue Service.

PRP is determined by computing the difference between the medical costs covered by that plan and what would have been covered by a qualified plan and requiring the difference (up to $1,500) to be paid by the family in addition to the PRP under a fully qualified plan. Thus, the maximum PRP for non-qualified insurance is $1,500, plus the greater of $500 or 10 percent of family income.

Fully-qualified Medicare is defined as coverage under Parts A and B of Medicare and supplemental private insurance which together provide coverage equal to the fully-qualified plan above. The PRP for such a plan is $500 independent of income. Others covered by Medicare have a PRP of $1,000 independent of income.

Those who have no health insurance coverage have a PRP equal to the greater of $5,000 or 50 percent of income. People who are categorically eligible for Medicaid are fully covered under that program and hence are not assigned a PRP.

The administration of CHIP

The CHIP program is administered by the Rhode Island Department of Health. The department is authorized to contract with third-party payers to: serve as fiscal intermediaries for the program; audit administrative costs of the third parties; request review of potentially qualified plans by the Department of Business Regulation; certify HMO's for participation in the program; hear appeals on claim benefits decisions; and perform related functions.

The determination of eligibility is handled by the Division of Health Insurance in the Department of Health.

Persons wishing to make claims under CHIP must submit an application for eligibility to the Division of Health Insurance, where eligibility, validation of residence, computation of expenditures and amount of personal resource payment are de-

termined. Claimants who are eligible are issued an identification card and financial intermediaries are notified. Eligible claims are processed by the Metropolitan Life Insurance Company for persons with private coverage other than Blue Cross/Blue Shield. All other claims are processed by Blue Cross/Blue Shield of Rhode Island, including claims for persons without insurance. CHIP payments are made for eligible medical expenses at the rate of 100 percent of usual and customary costs for medical services and inpatient psychiatric services or 50 percent of usual and customary costs for outpatient psychiatric services. The insurers bill the state periodically for payments made and for administrative costs.

Limitations of the program

An examination of CHIP in the context of a comprehensive national health care plan such as that described by President Carter in July 1978 reveals the limitations of the program. Such a program will not assure comprehensive health care coverage, nor increase the availability of ambulatory and preventive services; nor will it contribute to aggressive cost containment, stimulate greater efficiency in the health care system, or control unnecessary health care spending. Furthermore, the program can have little effect on the geographic distribution of health care resources. Thus, a program like CHIP is not a panacea for the problems confronting the American health care system.

Diversity of CHIP recipients

The CHIP program data appearing in this and subsequent sections were abstracted from records and the Rhode Island Department of Health and its intermediaries. Data were collected through August 1978. Because the application deadline for eligibility in the 1977 calendar year is December 31, 1978, data for 1977 are subject to revision.

During the first year of the program, 156 families qualified for CHIP. Sixty-two of these families requalified the second year together with 161 new families. In 1977, 202 new families qualified and ninety families requalified. The population of Rhode Island was stable during these years at about 935,000 people.

CHIP is the last payer of health costs for the citizens of Rhode Island. Because of this feature, the program's statistics are useful in describing those people who incur large out-of-pocket health care expenses, in indicating what diseases give rise to those expenses, and in determining which health care services are not covered at the catastrophic level by basic types of health insurance and by public programs covering health care costs. Those diseases which result in catastrophic health care expenses do not strike totally at random, but occur more often in some high-risk group than in other groups, as described by age, sex, income, and so forth. However, the diversity of characteristics of the CHIP recipients is remarkable. The data demonstrate that no group as defined by age, sex, income, or insurance coverage is completely safe from catastrophic expenses as defined by this program.

It should be noted that although CHIP is a program based on family medical expenses, there is in almost every case a single family member whose expenditures dominate all the rest. The statistics on CHIP recipients describe only those "primary" family members. The per capita expenditure for "secondary" family members is much smaller than "per family" expenditures and only 2.2 percent of all expenditures are made by these family members.

Age-Sex of Recipients

Table 2 shows the age breakdowns of CHIP recipients and the population of Rhode Island. (Medicaid enrollees do not appear among CHIP recipients—CHIP recipients are drawn from a population with fewer of the very young and very old than the population at large.) Among new recipients, the younger age groups comprise a smaller percentage, and the older age groups a greater percentage, as might be expected. The greater frequency of males in the 5-14 age group is primarily in the mental condition diagnostic group. For females in the 15-44 age group, the greater frequency occurs for childbirth and mental conditions. Among reapplicants, the age groups 5-14 years and 15-44 years are more heavily represented than among new recipients. These figures are associated with the high rate of requalification among those with mental illness, the high mortality rates for the older age groups, and the high rate of recovery for the newborn.

Table 2. Age distribution of Rhode Island population (1975) and of CHIP recipients (1975–77)

Age group	Percent of population	Percent of CHIP recipients*	Percent of CHIP reapplicants
0 - 4	6.7%	5.6%	1.3%
5 - 14	17.3	4.4	7.9
15 - 44	41.4	33.9	36.8
45 - 64	22.6	31.0	27.0
65 +	12.0	25.0	27.0

* Excluding reapplicants.

Income of recipients

The income breakdown of CHIP recipients by type of health insurance appears in Table 3. It can be seen from the table that a high percentage of those with Medicare did not report their incomes. The reason being there is no income comparison in de-

Table 3. Family income* of CHIP recipients, by type of insurance, 1975–77

Gross family income	None	Private		Medicare		All
		Fully qualified	Semi- or nonqualified	Fully qualified	Semi-qualified	
$ 0 - 2,999	15	15	21	25	12	88
3,000 - 3,999	4	7	9	1	0	21
4,000 - 4,999	4	7	9	3	1	24
5,000 - 5,999	5	13	8	1	0	27
6,000 - 6,999	4	8	8	2	0	22
7,000 - 7,999	7	12	4	2	1	26
8,000 - 8,999	2	11	16	2	2	33
9,000 - 9,999	1	5	6	3	0	15
10,000 - 11,999	4	17	13	5	0	39
12,000 - 14,999	0	16	15	2	0	33
15,000 - 19,999	2	18	12	5	2	39
20,000 - 24,999	0	6	4	0	0	10
25,000 and above	0	7	2	7	0	16
Not reported	0	8	7	92	19	126
Total	48	150	134	150	37	519
Average	$5,261	$10,660	$8,924	$9,835	$3,709	$8,999

* In first year of eligibility

termining their deductible, so it is not necessary to know their incomes to consider their applications. Thus, the statistics for these two groups may be for a non-representative sample.

From the table, it can be determined that the average incomes of those with private health insurance ($9,840) and those with Medicare ($8,384) are well above that for those with no insurance. For median incomes, the situation is different—the median incomes being in the $5,000 - $5,999 range for those with no insurance, in the $8,000 - $8,999 range for those with private coverage, and at the $4,000 break for those with Medicare. The discrepancy is caused by there being many Medicare recipients in the lowest income group (Social Security benefits are not taxable income) and by the two largest reported incomes among CHIP recipients ($78,000 and $60,000) falling in the Medicare group.

Medical conditions of recipients

Table 4 shows the medical conditions of CHIP recipients. New and repeat qualifiers are included. Circulatory problems (heart attack, stroke, hardening of the arteries), cancer, mental illness, kidney disease, and injuries all appear prominently on the list. The unexpectedly large groups include normal and complicated deliveries and prematurity. The diversity of medical conditions which can lead to catastrophic out-of-pocket costs is apparent.

Among the larger illness groups, the requalification rate was largest for those with mental illness (37.1 percent), circulatory disorders (27.9 percent), and cancer (22.4 percent). Smaller categories with high requalification rates were musculoskeletal diseases such as arthritis (88.9 percent) and nervous system diseases such as multiple sclerosis (56.0 percent).

Table 4 also shows the breakdown of medical condition by type of health insurance. Since Medicare is limited to the aged and permanently disabled, it is not surprising to find relatively large numbers with circulatory problems, respiratory problems, and kidney disease. The high out-of-pocket expenditures result from

Table 4. Medical condition of CHIP recipients* by insurance type, 1975–77

Medical condition group**	Type of health insurance					Total
	None	Private		Medicare		
		Fully qualified	Semi- or nonqualified	Fully qualified	Semi-qualified	
I. Infective, parasitic	0	0	1	0	0	1
II. Neoplasms	8	17	37	33	7	102
III. Endocrine, nutritional, metabolic	0	2	2	4	0	8
IV. Blood and blood-forming organs	0	5	2	1	5	13
V. Mental disorders	4	92	22	8	4	130
VI. Nervous system, sense organs	2	16	7	14	2	41
VII. Circulatory system	8	18	22	65	12	125
VIII. Respiratory system	2	0	3	10	1	16
IX. Digestive system	13	6	6	6	2	33
X. Genitourinary System	0	3	7	38	10	58
XI. Delivery, pregnancy, childbirth	2	25	11	0	1	39
XII. Skin, subcutaneous tissue	0	0	0	1	0	1
XIII. Musculoskeletal, connective tissue	2	1	6	9	2	20
XIV. Congenital anomalies	0	9	4	0	0	13
XV. Newborn conditions	5	3	11	0	0	19
XVI. Ill-defined conditions	2	1	1	2	0	6
XVII. Injuries, adverse effects	10	3	8	16	3	40
Missing information	0	0	3	2	1	6
Total	58	201	153	209	50	671

* Including reapplicants' conditions (as reported in second and third years of eligibility)

** These groups are based on the widely used International Classification of Diseases, Adapted.

the restricted scope of services covered, the limits on payments for covered services, and the coinsurance paid by those with semi-qualified Medicare. Similarly, those people with private insurance are likely to appear in categories such as mental disorders and childbirth where the required services generally are not well covered by their plans. Conditions which lead to long periods of debilitation requiring extensive medical care, such as cancer and health disease, also frequently result in qualification for CHIP as a result of coinsurance payments and restrictions on services covered. Those with no insurance appear most often in the categories of digestive system diseases and accidental injuries.

Medical services used by recipients

Table 5 presents the largest eligible out-of-pocket expense incurred by a single family in a single year. The surprising aspect of these figures is that the largest expenditure on each service would by itself be considered catastrophic for at least one of the various insurance groups. Furthermore, the high expenditures listed for services such as hospital outpatient care, outpatient laboratory tests, and prescription drugs highlight the importance of extending catastrophic benefits to cover many types of care.

This table also presents the fraction of CHIP families that incurred out-of-pocket expenses on each type of service during an eligibility year. The only item on which a majority of CHIP families had some expense was prescription drugs; on only three other items did a quarter or more of CHIP families have some expense. These were hospital inpatient (medical), physician inpatient (medical) and physician outpatient (medical).

Table 5. Largest expenditures incurred and percent of families incurring expenditure, by type of service, 1975–77

Service	Largest family expenditure incurred	Families* incurring expenditures (percent)
Hospital inpatient (medical)	$64,878	47.7
Hospital outpatient (medical)	15,493	8.3
Physician inpatient (medical)	5,923	38.2
Physician outpatient (medical)	1,490	37.9
Hospital inpatient (psychiatric)	55,044	14.2
Hospital outpatient (psychiatric)	2,026	0.7
Physician inpatient (psychiatric)	3,850	6.0
Physician outpatient (psychiatric)	8,454	14.0
Nursing home	24,659	17.3
Laboratory (outpatient)	21,398	23.5
Prescription drugs	15,902	53.9
X-ray (outpatient)	700	15.9
Radiotherapy	2,215	1.3
Rehabilitative therapy	1,527	3.0
Private nursing	31,610	9.8
Ambulance	720	15.4
Durable medical supplies	3,890	7.7
Hemodialysis	4,390	5.8
Annual claim	$73,798	

* Including total CHIP enrollment of 671 new and requalifying families.

Recovery status of CHIP beneficiaries

A major uncertainty which arises when catastrophic health plans are discussed is whether the enactment of such a plan will encourage the utilization of extensive amounts of medical care by those for whom the care is only marginally, if at all, beneficial. The nature of the Rhode Island plan, with full coverage beyond the personal resource payment, seems to lend itself to the encouragement of over-utilization of life-sustaining technology in terminal and severe chronic cases. Thus such a program may give rise to increased demand for these sorts of services and, in turn, lead to the shifting of health resources from areas where they may be more beneficial.

Table 6 reports the outcomes of CHIP recipients who qualified in the first two years of the program. All primary recipients of CHIP benefits in the years 1975 and 1976 have been divided into four groups depending on their later status in regard to the program. First, all those who were deceased by April 1978 were placed in one category. Of the remainder, those who were still CHIP recipients in 1977 were placed in the "chronic" category. Finally, those who were over 65 or who received Medicare benefits under the chronic disability provision were separated from those who could be assumed employable. CHIP recipients in 1977 could not be so grouped because the application period for 1978 eligibility extended through December 1979. Indeed, some 1976 recipients presently classified as recovered and aged or disabled may reapply to CHIP in the remaining months of 1978, although this would not blunt the force of the statistics presented in the table.

This table shows that out of the 156 CHIP recipients in 1975, 47 had died and 67 had recovered sufficiently to be off CHIP rolls in 1977. Of the 223 recipients in 1976, 64 were deceased and 71 were considered recovered. The preponderance of non-employables among the CHIP recipients of these years is striking, with nearly two-thirds of all the recipients in groups other than the recovered. The expenditure data in Table 7 reinforces the

pattern presented in the previous table, with well over half of all expenditures going to the nonemployable groups. The percentage of total benefits paid to the recovered group decreased substantially from 1975 to 1976, but the percentage of CHIP recipients in that category fell even more rapidly. These decreases may simply be due to the fact that the recovered group for 1975 includes those who qualified for CHIP in both 1975 and 1976 but not in 1977 (as well as those who qualified for 1975 but not 1976), whereas the recovered group for 1976 includes only those who qualified for 1976 but not 1977. Thus the 1975 recipients have had an "extra" year to recover, and therefore the numbers are not strictly comparable.

Table 6. Recovery status of CHIP recipients, 1975–76

Recovery status	Year of benefits		Total
	1975	1976	
Chronic recipients	27	70	97
Recipients off CHIP	129	153	282
Deceased	47	64	111
Aged or disabled	15	18	33
Recovered	67	71	138
All except recovered	89	152	241
All recipients	156	223	379

Table 7. Benefits paid to CHIP recipients, by recovery status

Recovery status	Percent of benefits paid		
	Year of benefits		Total
	1975	1976	
Chronic recipients	23.4%	31.2%	27.8%
Recipients off CHIP	76.6	68.8	72.2
Deceased	25.4	26.4	26.0
Aged or disabled	3.2	3.1	3.1
Recovered	48.0	39.4	43.2
All except recovered	52.0	60.6	56.8
All recipients	100.0%	100.0%	100.0%

Benefits paid through CHIP

Data on benefits paid through CHIP are given in Table 8. It is clear that benefits paid increased rapidly during these years.

Table 8. CHIP benefits paid and rates of increase

Calendar year	*Total CHIP benefits paid*	*Percent increase in benefits*
1975	$ 823,312	—
1976	1,058,203	28.5%
1977	1,283,750	21.3

In anticipation of the program, the state appropriated $1.8 million for the first year. The benefits paid under the program have yet to reach this level. Three aspects of this program contributed prominently to the increased expenditures. The benefits paid to Medicare recipients increased from $124,802 in 1975 to $425,764 in 1977. The benefits paid for psychiatric care increased from $174,836 in 1975 to $251,119 in 1977. Interrelated to the first two, the benefits paid for requalifiers was $332,636 in 1976 and $493,966 in 1977.

The introduction of any new financing program for health care calls to mind the inflationary and budgetary consequences of the Medicare and Medicaid programs. The inflationary potential of CHIP may be inferred from the program's contribution to aggregate health expenditures. Table 9 illustrates the relative importance of major third-party programs in paying for the various categories of services and supplies which are eligible for CHIP coverage. Included here are payments from Medicare, Medicaid, and Blue Cross/Blue Shield of Rhode Island. The data reported are for calendar year 1975.[1] Since these are mature programs, those statistics are relatively constant from year to year. Also included are data from the CHIP program for 1976. It is obvious that CHIP is tiny compared to any of the other programs. Thus, the CHIP program should not be expected to have the same inflationary consequences as Medicare and Medicaid.

Table 9. Third-party reimbursement for selected health services and supplies in Rhode Island

Service or supplies	Percent of total expenditures paid by Medicare	Medicaid	Blue Cross/ Blue Shield	CHIP
Hospital services	24.5%	14.6%	27.4%	0.2%
Physician services	14.9	5.2	37.7	0.1
Other professionals	15.3	16.8	10.4	0.4
Prescription drugs	—	21.8	5.9	0.1
Eyeglasses and appliances	—	3.6	—	0.0
Nursing homes	3.9	42.1	0.1	0.3
Other services	19.4	—	9.1	0.1

[1] For more information on aggregate health expenditures in Rhode Island, see Harvey Zimmerman and Jay Buechner, "Health Expenditures in Rhode Island, 1975," *SEARCH Reports*, No. 21, May 1978.

Conclusion

The experience under the first three years of operation of CHIP demonstrates the kind of inadequacies present in existing health insurance plans. Although some groups in the population are at greater risk than others, no group is completely safe from catastrophic out-of-pocket health care expenses. As can be expected in a program of this kind, chronic and fatal conditions predominate. However, the proportion of recipients who appear to have recovered is sufficient to suggest that the economic benefits of the program may outweigh the costs.

Areas for further research

This first look at the operational experience under a catastrophic out-of-pocket cost program for health care suggests areas for future research. It would be instructive to investigate the costs paid by third parties in addition to those paid by CHIP recipients and by the program. For prevalent conditions such as cancer, this additional information could contribute to a greater understanding of the extent to which third-party programs influence the treatment regimen. It would also be interesting to determine how or even if, the $5,000 minimum personal resource payment for those people with no insurance is paid. In addition, it would be of interest to know the effects on the program of reducing this minimum payment.

More years of data on Rhode Island's Catastrophic Health Insurance Program would provide better knowledge of the outcome of recipients and facilitate analysis of CHIP's effectiveness. It would also allow an evaluation of the long-term effects of the program on the basic pattern of health insurance coverage and the observation and analysis of annual program growth after the start-up period has passed. Finally, data from Rhode Island could be combined with data from states with similar programs to permit better estimates of expected program costs for other geographical areas, including the costs of possible national catastrophic plans.

NCHSR Fact Sheets

NCHSR Fact Sheets provide concise information on NCHSR's organization and mission, as well as on key problems in health services and research directed toward health care problems.

National Center for Health Services Research (English)

National Center for Health Services Research (Spanish)

National Center for Health Services Research (Chinese)

NCHSR Research Focus, 1981–1982

Health Care and the Disadvantaged

Hospital Cost and Utilization Project

Maternal and Child Health Care

National Health Care Expenditures Study

United Mine Workers of America Health Care Plan

Emergency Medical Services Systems

NCHSR Research Grant Application and Scientific/Technical Merit Review Procedures

Computer Applications in Health Care

Current NCHSR Publications

National Center for Health Services Research publications of interest to the health community are available on request to NCHSR, Publications and Information Branch, 3700 East-West Highway, Room 7-44, Hyattsville, MD 20782 (telephone: 301/436-8970). Mail requests will be facilitated by enclosure of a self-addressed, adhesive-backed mailing label. These publications also are available for sale through the National Technical Information Service (NTIS), Springfield, VA 22161 (telephone: 703/487-4650). PB and HRP numbers in parentheses are NTIS order numbers. Publications which are out of stock in NCHSR are indicated as available only from NTIS. Prices may be obtained from the NTIS order desk on request.

Research Digests

The *Research Digest Series* provides overviews of significant research supported by NCHSR. The series describes either ongoing or completed projects directed toward high priority health services problems. Issues are prepared by the principal investigators performing the research, in collaboration with NCHSR staff. Digests are intended for an interdisciplinary audience of health services planners, administrators, legislators, and others who make decisions on research applications.

(HRA) 76-3144 Evaluation of a Medical Information System in a Community Hospital (PB 264 353, available NTIS only)

(HRA) 76-3145 Computer-Stored Ambulatory Record (COSTAR) (PB 268 342)

(HRA) 77-3160 Program Analysis of Physician Extender Algorithm Projects (PB 264 610, available NTIS only)

(HRA) 77-3161 Changes in the Costs of Treatment of Selected Illnesses, 1951-1964-1971 (HRP 0014598, available NTIS only)

(HRA) 77-3163 Impact of State Certificate-of-Need Laws on Health Care Costs and Utilization (PB 264 352, available NTIS only)

(HRA) 77-3164 An Evaluation of Physician Assistants in Diagnostic Radiology (PB 266 507, available NTIS only)

(HRA) 77-3166 Foreign Medical Graduates: A Comparative Study of State Licensure Policies (PB 265 233, available NTIS only)

(HRA) 77-3171 Analysis of Physician Price and Output Decisions (PB 273 312)

(HRA) 77-3173 Nurse Practitioner and Physician Assistant Training and Deployment (PB 271 000, available NTIS only)

(HRA) 77-3177 Automation of the Problem-Oriented Medical Record (PB 266 881, available NTIS only)

(PHS) 78-3190 Uncertainties of Federal Child Health Policies: Impact in Two States (PB 283 202)

(PHS) 80-3229 Responses of Canadian Physicians to the Introduction of Universal Medical Care Insurance: The First Five Years in Quebec (PB 80-137 979)

(PHS) 79-3231 Israel Study of Socialization for Medicine (PB 293 887)

(PHS) 79-3235 AAMC Longitudinal Study of Medical School Graduates of 1960 (PB 294 689)

(PHS) 79-3238 Some Effects of Quebec Health Insurance (PB 294 097)

(PHS) 79-3261 Medical Education Financing: Issues and Options (PB 80-134 851)

(PHS) 80-3285 A Social and Economic Analysis of Professional Regulation in Optometry

Research Summaries

The *Research Summary Series* provides rapid access to significant results of NCHSR-supported research projects. The series presents executive summaries prepared by the investigators. Specific findings are highlighted in a more concise form than in the final report. The *Research Summary Series* is intended for health services administrators, planners, and other research users who require recent findings relevant to immediate programs in health services.

(HRA) 77-3162 Recent Studies in Health Services Research, Vol. I (July 1974 through December 1976) (PB 266 460)

(HRA) 77-3176 Quality of Medical Care Assessment Using Outcome Measures (PB 272 455)

(HRA) 77-3183 Recent Studies in Health Services Research, Vol. II (CY 1976) (PB 279 198)

(PHS) 78-3187 Criterion Measures of Nursing Care Quality (PB 287 449)

(PHS) 77-3188 Demonstration and Evaluation of a Total Hospital Information System (PB 271 079)

(PHS) 78-3192 Assessing the Quality of Long-Term Care (PB 293 473)

(PHS) 78-3193 Optimal Electrocardiography (PB 281 558)

(PHS) 78-3201 A National Profile of Catastrophic Illness (PB 287 291)

(PHS) 79-3223 Medical Direction in Skilled Nursing Facilities (PB 300 845)

(PHS) 79-3230 Per-Case Reimbursement for Medical Care (PB 294 688)

(PHS) 79-3236 Nurse Practitioners and Physician Assistants: A Research Agenda (PB 294 084)

(PHS) 80-3244 Quality of Ambulatory Care
(PHS) 79-3247 A Demonstration of PROMIS
(PHS) 79-3248 Effects of the 1974-75 Recession on Health Care for the Disadvantaged (PB 80-138 449)
(PHS) 79-3250 Effects and Costs of Day Care and Homemaker Services for the Chronically Ill: A Randomized Experiment (PB 301 171)
(PHS) 80-3265 How a Medical Information System Affects Hospital Costs: The El Camino Hospital Experience
(PHS) 80-3266 Developing a Quality Assurance Strategy for Primary Care (PB 80-162 878)

Research Reports

The *Research Report Series* provides significant research reports in their entirety upon the completion of the project. Research Reports are developed by the principal investigators who conducted the research, and are directed to selected users of health services research as part of a continuing NCHSR effort to expedite the dissemination of new knowledge resulting from its project support.

(HRA) 77-3152 How Lawyers Handle Medical Malpractice Cases (HRP 0014313)
(HRA) 77-3159 An Analysis of the Southern California Arbitration Project, January 1966 through June 1975 (HRP 0012466)
(HRA) 77-3165 Statutory Provisions for Binding Arbitration of Medical Malpractice Cases (PB 264 409, available NTIS only)
(HRA) 77-3184 1960 and 1970 Spanish Heritage Population of the Southwest by County (PB 280 656, available NTIS only)
(HRA) 77-3189 Drug Coverage under National Health Insurance: The Policy Options (PB 272 074)
(PHS) 78-3204 Experiments in Interviewing Techniques: Field Experiments in Health Reporting (PB 276 080, available NTIS only)
(PHS) 79-3210 Telehealth Handbook: A Guide to Telecommunications Technology for Rural Health Care, (PB 292 557, available NTIS only)
(PHS) 78-3211 Emergency Medical Technician Performance Evaluation (PB 285 961)
(PHS) 79-3217-1 Evaluation of Child Abuse and Neglect Demonstration Projects, 1974-77, Vols. 1 and 2 (PB 278 438 and 278 439; vols. 1-12, PB 278 437, the set)
(PHS) 78-3219 Needed Research in the Assessment and Monitoring of the Quality of Medical Care (PB 288 826)

(PHS) 79-3237 A Cost-Effective Approach to Cervical Cancer Detection (PB 295 515)

(PHS) 79-3245 Costs and Benefits of Electronic Fetal Monitoring: A Review of the Literature (PB 294 690)

(PHS) 79-3251 Computer Applications in Health Care (PB 300 838)

(PBS) 79-3258 Effects and Costs of Day Care and Homemaker Services for the Chronically Ill: A Randomized Experiment (PB 80-138 100)

(PHS) 80-3263 Health Status, Medical Care Utilization, and Outcome: An Annotated Bibliography of Empirical Studies; Parts I-IV (PB 284 997, available NTIS only)

Research Proceedings

The *Research Proceedings Series* extends the availability of new research announced at key conferences, symposia and seminars sponsored or supported by NCHSR. In addition to papers presented, publications in this series include discussions and responses whenever possible. The series is intended to help meet the information needs of health services providers and others who require direct access to concepts and ideas evolving from the exchange of research results.

(HRA) 77-3154 Advances in Health Survey Research Methods (PB 262 230, available NTIS only)

(HRA) 77-3181 NCHSR Research Conference Report on Consumer Self-Care in Health (PB 273 811)

(HRA) 77-3186 International Conference on Drug and Pharmaceutical Services Reimbursement (PB 271 386)

(PHS) 78-3195 Emergency Medical Services: Research Methodology (PB 279 096)

(PHS) 78-3207 Health Survey Research Methods, Second Biennial Conference (PB 293 492)

(PHS) 78-3208 Drug Coverage Under National Health Insurance (PB 293 468)

(PHS) 79-3209 Health Services Research in Puerto Rico (PB 292 326)

(PHS) 80-3215 Cost Accounting for Pharmaceutical Services (PB 80-157 936)

(PHS) 79-3216 Medical Technology: The Culprit Behind Health Care Costs? (PB 299 408)

(PHS) 79-3225-1 Emergency Medical Services Research Methodology: Workshop 1 (PB 294 048)

(PHS) 79-3225-2 Emergency Medical Services Research Methodology: Workshop 2 (PB 80-142 292)

(PHS) 78-3227 Effects of the Payment Mechanism on the Health Care Delivery System (PB 291 231)

(PHS) 79-3228 A National Conference on Health Policy, Planning, and Financing the Future of Health Care for Blacks in America (PB 292 559)
(PHS) 79-3233 Emergency Medical Services Systems as a Health Services Research Setting (PB 297 102)
(PHS) 79-3254 Medical Technology (PB 80-149 511)
(PHS) 79-3256 Sharing Health Care Costs (PB 80 162 795)
(PHS) 79-3257 Health Facility Reuse, Retrofit, and Reconfiguration (PB 80-142 383)

Research Management

The *Research Management Series* describes programmatic rather than technical aspects of the NCHSR research effort. Information is presented on the NCHSR goals, research objectives, and priorities; in addition, this series contains lists of grants and contracts, and administrative information on funding. Publications in this series are intended to bring basic information on NCHSR and its programs to research planners, administrators, and others who are involved with the allocation of research resources.

(PHS) 79-3220 Emergency Medical Services Systems Research Projects, 1978 (PB 292 558)
(PHS) 80-3271 Emergency Medical Services Systems Research Projects Abstracts, 1979

NHCES

The *National Health Care Expenditures Study Series* presents information and analyses on critical national health policy issues. Basic data were obtained from the National Medical Care Expenditure Survey, a statistical picture of how health services are used and paid for. Data Previews give preliminary estimates of key measures.

(PHS) 80-3276 Data Preview 1: Who are the Uninsured?
(PHS) 80-3275 Data Preview 2: Charges and Sources of Payment for Dental Visits with Separate Charges
(PHS) 80-3278 Data Preview 3: Who Initiates Visits to Physicians' Offices?
(PHS) 80-3290 Data Preview 4: Health Insurance Coverage of Veterans

(PHS) 80-3291 Data Preview 5: Charges and Sources of Payment for Visits to Physician Offices

(PHS) 80-3296 Data Preview 6: Waiting Times in Different Medical Settings: Appointment and Office Waits

Policy Research

The *Policy Research Series* describes findings from the research program that have major significance for policy issues of the moment. These papers are prepared by members of the staff of NCHSR or by independent investigators. The series is intended specifically to inform those in the public and private sectors who must consider, design, and implement policies affecting the delivery of health services.

(HRA) 77-3182 Controlling the Cost of Health Care (PB 266 885)

Program Solicitations

(PHS) 81-3292 Grants for Research on Health Promotion and Disease Prevention

(PHS) 81-3293 Extramural Associates Program, 1981

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